

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

## CERTIFICATE OF DEATH

04737

Reg. Dist. No. 92

### 1. PLACE OF DEATH:

County Cecil  
City or town Cecil  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution Union Hosp.  
Stay in hospital or inst. (yrs., or mos., or days) 10 months  
Stay in this community (yrs., or mos., or days)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Cecil  
City or town Cecil  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. \_\_\_\_\_  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Millie B. Black

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife J. W. Black  
6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Dec 28 1892

8. AGE: Years 73 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cecil Md.  
(Town, county, and state)

10. Usual occupation at home

### 11. Industry or business

12. Name James J. Watts Md.  
13. Birthplace Martha J. Pearce Md.

14. Maiden name Martha J. Pearce Md.  
15. Birthplace

16. Informant J. W. Black  
Address Cecil Md.

17. Burial  
(Burial, cremation, or removal. Which?) Date thereof May 18 '46  
(month) (day) (year)  
Cemetery or crematory Cecil Md.  
Location Edwards Fellowship

18. Funeral director Edwards Fellowship  
Address Millington Md.

19. May 16 1946 J. H. Frazer  
(Date read by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1946 at 7:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1946  
and that I last saw her alive on May 15 1946

### Immediate cause of death

Myocarditis  
Due to Chronic arthritis

### Due to

### Other conditions

(Include pregnancy within 3 months of death)

### Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

### DURATION

3 weeks  
many years

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

### 23. SIGNATURE

Thos. J. Donohue M. D. or other  
Address Chesapeake Date signed 5/16/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 938

## CERTIFICATE OF DEATH

★ 04738

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County Cecil  
 City or town Carlville  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

Life

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Cecil  
 City or town Carlville Ward No. \_\_\_\_\_  
 (If outside city or town limits, write RURAL NEAR and give town)

Street No. \_\_\_\_\_

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR \_\_\_\_\_

## 3. (a) FULL NAME

James P. Bolton

## 3. (b) Social Security Number

None

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife \_\_\_\_\_

8 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

Feb. 16, 1869

8. AGE:

Years

77

Months

3

Days

5

If less than one day

hrs.

min.

9. Birthplace

Carlville, Md. - Cecil Co.  
(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business \_\_\_\_\_

MOTHER

FATHER

12. Name

George Bolton

13. Birthplace

Md.

14. Maiden name

Benetta Raley

15. Birthplace

Md.

16. Informant

James P. Bolton Jr.

Address

Carlville, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 24, 1946  
(month) (day) (year)

Cemetery or crematory

Johnstown

Location

Md. Carlville, Md.

18. Funeral director

Edward Fellows

Address

Millington, Md.19. 5-24

(Date rec'd by registrar)

19. 46

## MEDICAL CERTIFICATION

20. DATE OF DEATH

5/21 1946 at 5:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1944 1944 to May 21 1946and that I last saw him alive on May 20 1946

Immediate cause of death

Thromboplegia

DURATION

2 days

Due to

My intense Cardio vascular

Due to

diseaseseveral  
years

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_

Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Henry D. Doms

M. D. or other

Address

Chesterfield, Md.

Date signed

5/21/46

RECEIVED

MAY 25 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16420

## CERTIFICATE OF DEATH

04739

★ Reg. Dist. No. 92

## 1. PLACE OF DEATH

County... *Sevier*  
 City or town... *Locust Point Eckton P.*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *6 days*  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... *MD* County... *Sevier*  
 City or town... *Eckton Rural*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

*Andrey C Charshiee*

## 3. (b) Social Security Number

4. Sex *M*5. Color or race *White*6. (a) Single, married, widowed, or divorced *married*6. (b) Name of husband or wife *Joseph Charshiee*7. Birth date of deceased (mo., day, yr.) *Dec. 8 1916*8. AGE: Years *29* Months *5* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace *Eck Mills Md.*  
(Town, county, and state)10. Usual occupation *Electrician*

11. Industry or business

12. Name *Harry H Carr*13. Birthplace *Bayview Md.*14. Maiden name *Sarah Ellen Momin*15. Birthplace *Stanton Del.*16. Informant *Harry H Carr*Address *Eck Mills Md.*17. *Burial* Date thereof *May 11 1946*  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory *Cherry Hill Cemetery*Location *Cherry Hill Maryland*18. Funeral director *H. W. Pippin*Address *Eckton Maryland*19. *May 11 1946* Registrar *JR Frazer*  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH *May 8 1946* at *11 P.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death *Perforating bullet wound of head.*

Due to \_\_\_\_\_ DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *suicide* Date of *5/8-46*Where did injury occur *Locust Point Cecil Md.* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *Cottage*Means of injury *22 Farset Pistol* Injured at work? *no*23. SIGNATURE *R L Davidson MD* Medical ExaminerAddress *Livingston Md.* Date signed *5/10-46*

RECEIVED  
MAY 18 1946  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No.

04740

90

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

William Lewis Dickhaut

## 3. (b) Social Security Number

288-01-8348A

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

married

## 8. (b) Name of husband or wife.....

## 7. Birth date of

deceased (mo., day, yr.)

March 3 1878

(c) If alive, give age..... years

## 8. AGE:

Years..... Months..... Days..... If less than one day..... hrs. .... min.

## 9. Birthplace.....

Retired Brick Layer

## 11. Industry or business

## 12. Name.....

## 13. Birthplace.....

## 14. Maiden name.....

## 15. Birthplace.....

## 16. Informant.....

## Address.....

## 17. Burial.....

## Date thereof.....

## (Burial, cremation, or removal, Which?)

## Cemetery or crematory.....

## Location.....

## 18. Funeral director.....

## Address.....

## 19. May 22 1946

## Date rec'd by registrar

## 19. 46

## Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19. 46, at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 46, to May 20 19. 46

and that I last saw him alive on May 20 19. 46

Immediate cause of death.....

Coronary Occlusion

Due to.....

Arterio Sclerosis

Due to.....

Hypertension

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAY 25 1946

BUREAU V.H.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

04742  
Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County CORRALL  
 City or town VETERANS ADMINISTRATION, PERRY POINT, MD.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 yrs. 5 mo. 8 da.  
 Hospital, institution, or street address where death occurred:  
Veterans Administration, Perry Point, Md.  
 How long in hospital or institution? Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County ---  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1817 Bolton St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ★ WW I

## 3. (a) FULL NAME

HARTLEY, William McKinley

## 3. (b) Social Security Number

-

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Widower  
 6.(b) Name of husband or wife Mrs. Irene Hartley  
 6.(c) If alive, give age --- years  
 7. Birth date of deceased (mo., day, yr.) September 11, 1896  
 8. AGE: Years 49 Months 8 Days 6 If less than one day --- hrs. --- min.

9. Birthplace Bloomington, Md.  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business ---  
 12. Name William Hartley  
 13. Birthplace Ohio  
 14. Maiden name Margaret Young  
 15. Birthplace Unknown

16. Informant Hospital Records  
 Address Veterans Administration, Perry Point, Md.  
 17. Removal 5-17-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Nethkin Hill Cemetery  
 Location Elk Garden, W. Va.  
 18. Funeral director Permongh & Son  
 Address Havre de Grace, Md.

19. May 17 19 46 Irene E. Doyle  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 19 46 at 12:40 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9 19 32 to May 17 19 46  
 and that I last saw him alive on May 17 19 46  
 Immediate cause of death Disease of the heart, coronary arteriosclerosis with myocardial damage over 13 yrs.  
 Due to ---  
 Due to ---  
 Other conditions Dementia Precox, Catatonic type over 13 yrs.  
 (Include pregnancy within 8 months of death)  
 Major findings of operations None Date of op. ---  
 Autopsy results Not performed  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide --- Date of ---  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) ---  
 Means of injury --- Injured at work? ---

23. SIGNATURE A. E. Hollinger, Jr.  
A. E. TROLLINGER, M.D., Clinical Director, Veterans Administration Hospital  
 Address Perry Point, Md. Date signed 5-17-46

RECEIVED  
MAY 21 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04743

## 1. PLACE OF DEATH:

County SevierCity or town Sevierton Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County SevierCity or town Sevierton Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Herman Burchard Hilgard

## 3. (b) Social Security Number

4. Sex M. 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Pearl Hilgard6. (c) If alive, give age 49 years7. Birth date of deceased (mo., day, yr.) July 22, 18928. AGE: Years 53 Months 9 Days 22 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.8. Birthplace Kennedysville Ind.  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name William Hilgard13. Birthplace Kent Co. Del.14. Maiden name Annie Burchard15. Birthplace Greenup Co Ind.16. Informant Betty HilgardAddress Earlsville Ind.17. Burial Date thereof May 17, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CrumptonLocation Crumpton, Maryland18. Funeral director Edward H. HousAddress Millington, Ind.19. 5-17 1946 Spring Burke  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1946 at 4 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_\_,

Immediate cause of death Gas Poisoning  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following;  
Accident, suicide, or homicide Suicide Date of 5/14-46  
Where did injury occur? Sevierton Sevier Ind.  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) Home  
Means of injury Automobile Injured at work?23. SIGNATURE R. L. Doolson Medical Examiner  
Address Sevierton Ind. County \_\_\_\_\_  
Date signed 5/15-46

RECEIVED

MAY 22 1946

BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 94

## 1. PLACE OF DEATH:

County Cecil  
 City or town North East Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Cecil  
 City or town North East Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

George Frederick Kennedy

## 3.(b) Social Security Number

208-22-3196

4. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mary E. Kennedy

7. Birth date of deceased (mo., day, yr.) October 11 1890 8.(c) If alive, give age 63 years

8. AGE: Years 55 Months 6 Days 10 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cecil Co. Md.  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name John Kennedy

13. Birthplace Cecil Co. Md.

14. Maiden name Mary Atkinson

15. Birthplace Cecil Co. Md.

16. Informant Birth R. Gray

Address North East Rd & Md.

17. Burial Date thereof May 13 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel

Location North East Rural

18. Funeral director Joseph R. Grant

Address North East Rd, Md.

19. 5/18 19 46 L. E. Circus  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 19 46 at 530 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Gun shot

wound of

head.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Anteopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Suicide Date of 5/10-46

Where did injury occur? North East Rural Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Single B. Shot Gun Injured at work?

23. SIGNATURE R. L. Dodson MD Medical Examiner  
Cecil County  
 M. D. or other \_\_\_\_\_  
 Address Prattville Md Date signed 5/11-46

RECEIVED  
MAY 15 1946  
BUREAU V. R.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13702

## CERTIFICATE OF DEATH

★ 04745 92  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Cecil  
City or town Cattaraugus  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
Union Hospital

How long in hospital or institution? 2 days

## 3. (a) FULL NAME

John Nelson Lawrence

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil  
City or town Cerryville, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Mary Stern Lawrence

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1881

8. AGE: Years 64 Months 8 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cerryville Cecil, Md.  
(Town, county, and state)

10. Usual occupation Tailor

11. Industry or business Tire House

12. Name James F. Lawrence

13. Birthplace Cecil Co. Md.

14. Maiden name Mary A. Murphy

15. Birthplace Cecil Co. Md.

16. Informant Elizabeth Lawrence

Address Cerryville, Md.

17. Burial (Burial, cremation, or removal. Which) Burial

Date thereof May 12, 1946  
(month) (day) (year)

Cemetery or crematory Cathary Cemetery

Location Cerryville, Md.

18. Funeral director Ed A. Patterson & Son

Address Cerryville, Md.

19. May 16, 1946 J. R. Frazer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5/15 19 46 at 6:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/13 19 46 to 5/15 19 46 and that I last saw him alive on 5/14 19 46

Immediate cause of death \_\_\_\_\_

Chemia DURATION 3 days

Due to Chronic hypertrophy of prostate 4 months

Due to \_\_\_\_\_

Other conditions Retention of urine  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. J. Davis MD M. D. or other

Address Cerryville, Md. Date signed 5/16/46



DEPARTMENT OF TREASURY

UNITED STATES OF AMERICA

RECEIVED  
MAY 21 1946  
BUREAU V.C.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 138

04746

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

### 1. PLACE OF DEATH:

County CECIL  
City or town Veterans Administration, Perry Point, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 14 yrs. 2 mo. 11 da.  
Hospital, institution, or street address where death occurred:  
Veterans Administration, Perry Point, Md.  
How long in hospital or institution? 14 yrs. 2 mo. 11 da.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md. County ---  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1739 Wilkens Avenue  
(If rural, give LOCATION)  
2(a) If veteran, name war WW I

### 3. (a) FULL NAME

MAGUIRE, Jeremiah

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife ---

7. Birth date of deceased (mo., day, yr.) February 28, 1896 6. (c) If alive, give age --- years

8. AGE: Years 50 Months 2 Days 9 If less than one day --- hrs. --- min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business ---

12. Name Andrew Maguire

13. Birthplace County Cork, Ireland

14. Maiden name Margaret Dee

15. Birthplace Ireland

16. Informant Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal 5-7-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral Cemetery

Location Baltimore Md.

18. Funeral director John J. Cowan & Son

Address 904 Hollins St., Baltimore, Md.

19. May 7 19 46 James E. Blaylock  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 19 46 at 1:06 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-26-32 19 --- to May 7 19 46

and that I last saw him alive on May 7 19 46

Immediate cause of death Tuberculosis, pulmonary, far advanced, active DURATION 1 yr.

Due to ---

Due to ---

Other conditions Dementia Precox, Hebephrenic  
Type --- 15 yrs.  
(Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---

Autopsy results Not performed  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State) ---

Injured at home, farm, industry, public place (where?) ---

Means of Injury --- Injured at work? ---

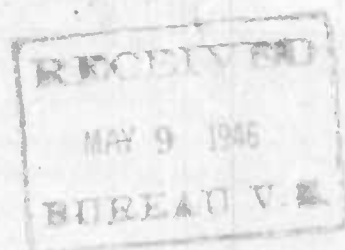
23. SIGNATURE J. E. Clarke  
J. E. CLARKE, M.D., Manager, Veterans Administration Hospital, Perry Point, Md.

Date signed 5-7-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County ElktonCity or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

Belle Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William Henry Massey

## 3. (b) Social Security Number

212-14-3563

## 4. Sex

M.

## 5. Color or race

Col

## 6.(a) Single, married, widowed, or divorced

widowed

## 6.(b) Name of husband or wife

Mealy Massey

6.(c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

March 15 1892

## 8. AGE:

Years 54Months 2Days 16

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Durham North Carolina  
(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

Son Massey

## FATHER

## 12. Name

Son Massey

## 13. Birthplace

North Carolina

## MOTHER

## 14. Maiden name

Flora Spear

## 15. Birthplace

North Carolina

## 16. Informant

## Address

Rott Massey  
Eugene North Carolina

## 17. Removal

## Date thereof

June 3 '46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

## Cemetery or crematory

Massey Cemetery

## Location

Durham North Carolina

## 18. Funeral director

## Address

H. W. Pippin & Son  
Elkton Md

## 19. Date rec'd by registrar

June 3 1946J. R. Frazer  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1946 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

acute coronary thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Blair Dockson  
Address Rising Sun Md Date signed 5/31-46

Medical Examiner

for Cecil County

M. D. or other

RECEIVED

JUN 6 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49

## CERTIFICATE OF DEATH

Reg. Dist. No. 04748 95

## 1. PLACE OF DEATH

County Cecil  
 City or town North East Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 years  
 Hospital, institution, or street address where death occurred  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Cecil  
 City or town North East Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

Bertha May Mc Dowell

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed or divorced Widowed  
 6. (b) Name of husband or wife Harvey S. McDowell  
 7. Birth date of deceased (mo., day, yr.) July 4 1891 8. (c) If alive, give age years  
 8. AGE: Years 54 Months 10 Days 23 If less than one day  
 hrs. min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1 1945, to May 27 1946  
 and that I last saw her on May 26 1946

Immediate cause of death Pulmonary Carcinoma  
RT upper lobe. DURATION 7 months

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F.B. Robinson M.D.Address Oxford Pura M.D. or other 5-27-46  
 Date signed19. May 29 1946 Registrar

(Date rec'd by registrar)

Received 5-29-46

RECEIVED

MAY 31 1946

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

## CERTIFICATE OF DEATH

Reg. Dist. No. 04740 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Bainbridge, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 days  
 Hospital, institution, or street address where death occurred:  
U.S. Nav. Hospital, (NTC), Bainbridge, Md.  
 How long in hospital or institution? 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Connecticut County \_\_\_\_\_  
 City or town New London  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 105 Lombard Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War (two) ✓

## 3.(a) FULL NAME

Mc KEON, Jr. John Joseph

## 3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced S  
 B.(b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) April 18, 1928 8.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 18 Months 0 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace New London, Conn.  
 (Town, county, and state)  
 10. Usual occupation U.S. NAVY  
 11. Industry or business \_\_\_\_\_  
 12. Name John Joseph McKeon Sr.  
 13. Birthplace Unknown  
 14. Maiden name Mary Mc Keon  
 15. Birthplace Unknown

16. Informant U.S. Nav. Hospital  
 Address Bainbridge, Maryland

17. Removal Removal Date thereof May 13, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Consigned  
 Location New Haven, Conn.  
 18. Funeral director Joseph A. Patterson  
 Address Perryville, Maryland

19. May 13 19 46 John E. Daugherty  
 (Date recd. by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11 MAY 19 46, at 4:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_  
 and that I last saw him alive on 5-11-46 19 \_\_\_\_\_  
 Immediate cause of death Uremia, Acute Pulmonary edema and Congestion

Due to Acute Glomerulo-Nephritis DURATION 2 wks.Due to Acute Mitral Valvulitis 2 wks.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results Above: Clinical & Autopsy findings

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of \_\_\_\_\_Where did injury occur? None  
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work?Signature Thomas A. Hedrick23. SIGNATURE Thomas A. Hedrick Lieut. (MC), USNR  
 M. D. or otherAddress U.S.N.H. Bainbridge, Md. Date signed 5-11-46

RECEIVED

MAY 15 1944

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1752

## CERTIFICATE OF DEATH

Reg. Dist. No. 04750

## 1. PLACE OF DEATH:

County CECILCity or town BAINBRIDGE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Apt. 4, Bldg. 914, Bainbridge Village

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CECILCity or town BAINBRIDGE VILLAGE  
(If outside city or town limits, write RURAL and give nearest town)Street No. Bldg. 914, Apt. 4  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Dennis Welch MILLER

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife None

7. Birth date of

deceased (mo., day, yr.)

February 1, 1946

8. AGE:

Years

Months

Days

If less than one day

313

.....hrs.

.....min.

9. Birthplace Bainbridge, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name MILLER, Lloyd James, S2/c13. Birthplace Providence, R. I.14. Maiden name Sirkka Singeld Seppanen15. Birthplace Finland16. Informant L. J. MillerAddress Bainbridge Village17. Burial Date thereof May 17, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19. May 17, 1946 Dr. E. D. Smith  
(Date received by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 46 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

did not see 19..... to 19.....  
and that I last saw him alive 19.....

Immediate cause of death

Asphyxiation

DURATION

Due to Aspiration of vomited milk  
curds while in crib, unattendedDue to Pronounced dead by Lt. Comdr. Paul  
Stuck at Bainbridge Village  
Other conditions Baby brought US Naval Hosp. Bainbridge  
Resuscitation efforts failed  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results 5-15-46 - Confirmed Diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Bl. Dodson Medical Examiner  
Cecil County  
M. D. or otherAddress Kingdom Ind. Date signed 5/15-46

RECEIVED  
MAY 18 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 04751 92

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Elkton  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Cecil  
 City or town..... Elkton RD 4  
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... RD 4  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Anna Monseceivity

## 3.(b) Social Security Number

## 4. Sex

F.

## 5. Color or race

Wh.

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Anthony Monseceivity

## 7. Birth date of

deceased (mo., day, yr.)

## 8. AGE:

55

Years

10

Months

10

Days

-

hrs.

-

min.

## 9. Birthplace

Ukrain Lithuanian

## 10. Usual occupation

at home

## 11. Industry or business

## FATHER

## 12. Name

Mr. Krow

## 13. Birthplace

Lithuania

## MOTHER

## 14. Maiden name

Mr. Krow

## 15. Birthplace

Lithuania

## 16. Informant

Anna Skupelke

## Address

3637 North Perry St Philadelphia Pa

## 17. Removal

(Burial, cremation, or removal, Which?)

Philadelphia

## Location

Philadelphia Pa

## 18. Funeral director

H.W. Pippin

## Address

Elkton, Md

## 19. May 25 1946

(Date rec'd by registrar)

J.H. Fraser

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1946 at 1030 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 21 1946 to May 25 1946

and that I last saw him alive on May 24 1946

Immediate cause of death

Chronic Intestinal

Dyspepsia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. L. Dodson M.D.

Address

Rear 9th St Philadelphia

Date signed 5/25-46

RECEIVED

JUN 4 1946

BUREAU V.E.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1226

## CERTIFICATE OF DEATH

04752

96

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Veterans Administration, Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 yrs. 18 days  
 Hospital, institution, or street address where death occurred:

Veterans Administration Hospital, Perry Point, Md.

How long in hospital or institution?..... Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Louisiana County..... Orleans

City or town..... New Orleans  
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... 1322 Felicity St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war..... WW I

## 3. (a) FULL NAME

MURPHY, John H. Jr.

## 3. (b) Social Security Number

-

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single

6.(b) Name of husband or wife..... None

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... January 1, 1897

8. AGE: Years..... 49 Months..... 4 Days..... 21 It less than one day..... hrs. .... min.

9. Birthplace..... New Orleans, La.  
 (Town, county, and state)

10. Usual occupation..... Unknown

11. Industry or business.....

12. Name..... John H. Murphy

13. Birthplace..... County Down, Ireland

14. Maiden name..... Ella Hart

15. Birthplace..... New Orleans, La.

16. Informant..... Hospital Records

Address..... Veterans Administration, Perry Point, Md.

17. Removal..... Removal Date thereof..... 5-22-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Joseph's Cemetery

Location..... New Orleans, Louisiana

18. Funeral director..... Pennington & Son

Address..... Havre de Grace, Md.

19. May 22 19 46 Irma S. Doughty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 22 19 46 at 4:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 19 44 to May 22 19 46

and that I last saw him alive on May 22 19 46

Immediate cause of death..... Intestinal obstruction DURATION..... 4 hrs.

Due to..... Foreign body (cloth) Unknown

Due to.....

Other conditions..... Dementia Precox, Hebe-  
phrenic type 25 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations..... Same as above Date of op. May 21, 1946

Autopsy results..... Not performed  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

SIGNATURE..... W. H. Hollister M.D. Clinical Director  
 Address..... for the Registrar Date signed..... 5-23-46

MARGIN RESERVED FOR BINDING

VS A15 943-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAY 25 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 175-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH

County ElktonCity or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 hours

Hospital, institution, or street address where death occurred:

Union Hosp. Elkton Md.How long to hospital or institution? 3 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County ElktonCity or town Chesapeake City  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Wrestley Nelson

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

col

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 15 1899

## 8. AGE:

47

Months

Days

If less than one day

hrs. \_\_\_\_\_ min.

## 9. Birthplace

West Va

(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

## FATHER

12. Name

Frederick Nelson

## 13. Birthplace

no information

## MOTHER

## 14. Maiden name

no information

## 15. Birthplace

no information

## 16. Informant

Sarah Butler

## Address

Chesapeake City (R.D.) Md

## 17. Burial

Burial

## Date thereof

May 25th 1946

(Burial, cremation, or removal. Which?)

## Cemetery or crematory

none

## Location

Near Chesapeake City, Md

## 18. Funeral director

N.W. Pippin

## Address

Elkton, Md.

## 19. May 25 19 46

(Date rec'd by registrar)

J.R. Frazer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1946 et. 11:25 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death

Fracture of Rt side of skull, extradural cont.

Due to

branch of middle cerebral artery

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/21-46Where did injury occur? Home (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_Injured at home, farm, industry, public place (where?) IndustryMeans of injury fall limb Injured at work? yes

23. SIGNATURE

R.L. Dickson Medical ExaminerChesapeake City, Md Date signed 5/23-46

CERTIFICATE OF DEATH

RECEIVED  
MAY 28 1945  
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County CecilCity or town Cecilton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Cecilton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George W. Oldham

## 3. (b) Social Security Number

220-09-1036

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

Nov. 29, 1886

8. AGE:

Years

Months

Days

If less than one day

59

hrs. min.

9. Birthplace

Cecilton, Cecil Co., Md.  
(Town, county, and state)

10. Usual occupation

Bookkeeper

11. Industry or business

MOTHER

FATHER

12. Name

George Oldham

13. Birthplace

Md.

14. Maiden name

Mary R. Durney

15. Birthplace

Cecilton

18. Informant

Miss Helen Oldham

Address

Cecilton, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

June 3, 1946  
(month) (day) (year)

Cemetery or crematory

Galena

Location

Galena, Md.

18. Funeral director

Edward Fellows

Address

Millington, Md.

19.

(Date rec'd by registrar)

June 3, 1946Spring Duke

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1946 at 8:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1946 to May 31, 1946and that I last saw him alive on May 30, 1946

Immediate cause of death

Coronary thrombosis

DURATION

Due to

Arterio-sclerous 3 yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Miles  
Wilmington, Del.

M. D. or other

Date signed 6/1/46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JUN 5 1946  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04755 95  
Reg. Dist. No.

### 1. PLACE OF DEATH

County Cecil  
City or town Colara  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 50 yrs.  
Hospital, institution, or street address where death occurred:  
How long to hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Cecil  
City or town Colara  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary Jane Pierce

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Robert Pierce

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1865

8. AGE: Years 80 Months 9 Days 19 If less than one day hrs. min.

9. Birthplace Cecil Co. Md.  
(Town, county, and state)

10. Usual occupation house wife

11. Industry or business

12. Name William Coulson

13. Birthplace Cecil Co. Md.

14. Maiden name Anna Nickle

15. Birthplace md.

16. Informant Mrs. Street Riley

Address Colara, Md.

17. Burial Date thereof May 7, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory West Nottingham Cemetery

Location Colara, Md.

18. Funeral director Ralph M. Reed

Address Rising Sun, Md.

19. May 7 - 46 Registrar L. M. Northington

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 46 at 6 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death Diabetic Coma

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE R. L. Dodson Medical Examiner

Rising Sun, Md. M. D. or other

Address Date signed 5/6/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Permit issued May 7 - 1946



DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

## CERTIFICATE OF DEATH

04756

Reg. Dist. No. 96

1. PLACE OF DEATH:  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME.....  
3. (b) Social Security Number.....

4. Sex.....  
5. Color or race.....  
6. (a) Single, married, widowed, or divorced.....  
6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....  
8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace.....  
(Town, county, and state)  
10. Usual occupation.....

11. Industry or business.....  
12. Name.....  
13. Birthplace.....

14. Maiden name.....  
15. Birthplace.....

16. Informant.....  
Address.....

17. Burial.....  
(Burial, cremation, or removal. Which?) Date thereof.....  
(month) (day) (year)  
Cemetery or crematory.....  
Location.....

18. Funeral director.....  
Address.....

19. May 18 1946.....  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
20. DATE OF DEATH.....  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....  
and that I last saw him alive on.....  
Immediate cause of death.....  
Other conditions.....  
(Include pregnancy within 3 months of death)  
Major findings of operations.....  
Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide.....  
Where did injury occur?.....  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?).....  
Means of injury.....  
Injured at work?.....

23. SIGNATURE.....  
Address.....  
Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 22 1946  
BUREAU T. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil

City or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

John Rittenhouse

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed (6 yrs)

6. (b) Name of husband or wife

Annie Rittenhouse

7. Birth date of

deceased (mo., day, yr.)

July 31 - 1860

8. AGE:

83 9 17

9. Birthplace

North East - Md  
(Town, county, and state)

10. Usual occupation

Blacksmith

11. Industry or business

David N. Rittenhouse

12. Name

Md

13. Birthplace

Mary Ann DeBocca Little

14. Maiden name

Md

15. Birthplace

Mr. H. M. Rittenhouse

Address North East Md (Rural)

Bureau

Date thereof May 20 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Presby Cemetery

Location Zion, Md

Funeral director Joseph R. Grant

Address North East, Md

May 20 1946

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

City or town North East - Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1946 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that deceased died from

Mar 27 1946 10:00 May 17 1946 4:15

and that I last saw him alive on May 17 1946 4:15

Immediate cause of death

General arteriosclerosis

with atheroma - arterio-sclerosis

Due to Vascular involvement

DURATION

about one yr.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. M. Knight

Address Elkton - Md

Date signed 5/18/46

RECEIVED

MAY 22 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

04758

## CERTIFICATE OF DEATH

Reg. Dist. No. 95

## 1. PLACE OF DEATH

County Cecil Co.City or town New Rising Sun  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Loucile Shumate

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Mar 11 1946

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

28

hrs.

min.

9. Birthplace

Rising Sun Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Date there: May 22, 1946  
(month) (day) (year)BaptistConover Md.J.C. TysonRising Sun Md.Immorestrington

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Cecil Co.  
City or town Outside Rising Sun Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 20 1946, at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 1946, to May 20 1946

and that I last saw him alive on

May 19 1946

Immediate cause of death

Pneumonia

DURATION

48 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L.P. Shumate

M. D. or other

Address

Washington MdDate signed 5/21/46

RECEIVED  
MAY 28 1988  
BUREAU V.B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04759

## CERTIFICATE OF DEATH

Reg. Dist. No.

96

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Port Deposit, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 50 years  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil  
 City or town..... Port Deposit, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Levi Evans Taylor

## 3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widowed  
 6.(b) Name of husband or wife..... Margaret Jackson Taylor  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... July 16, 1864  
 8. AGE: Years..... 81 Months..... 10 Days..... 6 If less than one day..... hrs. .... min.

9. Birthplace..... Port Deposit, Cecil Co., Md.  
 (Town, county, and estate)  
 10. Usual occupation..... Farmer, Retired  
 11. Industry or business.....

FATHER 12. Name..... George Platte Taylor  
 13. Birthplace..... Staunton, Delaware  
 MOTHER 14. Maiden name..... Josephine Linton  
 15. Birthplace..... Port Deposit, Md. Rural  
 16. Informant..... Willis J. Taylor  
 Address..... Port Deposit, Md. Rural

17. Burial..... Burial Date thereof..... May 25, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Asbury  
 Location..... Port Deposit, Md. Rural

18. Funeral director..... Lee A. Patterson & Son  
 Address..... Cerryville, Md.

19. May 25, 46 Irene E. Dougherty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 22, 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Nov. 20, 1945 to May 20, 1946  
 and that I last saw him alive on May 20, 1946

Immediate cause of death..... Chronic Myocarditis DURATION..... 10 yrs.

Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... B. J. Johnson M.D. M. D. or other  
 Address..... Port Deposit, Md. Date signed..... 5/23/46

RECEIVED

MAY 28 1946

BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

Reg. Dist. No. 04760 92

### 1. PLACE OF DEATH

County Cecil  
City or town Elberton  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 45 minutes  
Hospital, institution, or street address where death occurred: Union Hospital Elberton  
How long in hospital or institution? 45 minutes

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil  
City or town North East R.D.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Agnes Weaver

### 3. (b) Social Security Number

None

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife William Weaver

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2 1862

8. AGE: Years 84 Months 4 Days 17 If less than one day hrs. min.

9. Birthplace Penna (Town, county, and state)

10. Usual occupation Housewife

### 11. Industry or business

12. Name Frank

13. Birthplace Penna

14. Maiden name Josephine Young

15. Birthplace Not known

16. Informant Miss Elizabeth Weaver

Address North East Md (Rural)

17. Burial Date thereof May 22, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union

Location Elberton Rural

18. Funeral director Joseph A. Chast

Address North East, Md.

19. May 20 1946 J. Frazier

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1946 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death

Myocardial failure

Due to Atherosclerosis of heart

Due to Rheumatism

Other conditions Pulmonary TB

& Bronchitis Pneumonia (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Medical Exam

23. SIGNATURE R. L. Dockson M.D.

Address P. O. Box 1000 North East, Md.

Date signed May 19 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 22 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 04761  
 Reg. Dist. No. 95

## 1. PLACE OF DEATH:

County Cecil  
 City or town Rising Sun P.D.# 2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Cecil Co.  
 City or town Rising Sun Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Lottie M. White

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife John L. White  
 7. Birth date of deceased (mo., day, yr.) Aug 19, 1874  
 6.(c) If alive, give age years

8. AGE: Years 71 Months 8 Days 17 If less than one day  
 hrs. min.

9. Birthplace Rawlansville Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Peoples  
 13. Birthplace Eastland, La. & Pa

MOTHER 14. Maiden name Hannah M. Rawlings  
 15. Birthplace Rawlansville Md.

16. Informant Maynard Foster  
 Address Rising Sun Md.

17. Buried Date thereof May 11, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory West Nottingham  
 Location Columbia Md.

18. Funeral director E. Tyson  
 Address Rising Sun Md.

19. May 9 - 46 2 Md Nottingham  
 Recd by Registrar Date signed 5-9-46 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 19 46 at 49 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-27 19 44 to May 8 19 46  
 and that I last saw him alive on May 7 19 46

Immediate cause of death Coronary  
myocarditis  
& nephritis

Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?

23. SIGNATURE R. L. Doolson  
 Address Rising Sun Md. M. D. or other  
 Date signed 5-8-46

RECEIVED  
MAY 11 1946  
BUREAU V.I.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04762 96

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Cecil  
City or town Perry Point, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 hr. 50 mts.  
Hospital, institution, or street address where death occurred:  
Veterans Administration Hospital, Perry Point Md.  
How long in hospital or institution? 1 hr. 50 mts.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Worcester  
City or town Berlin  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R.F.D. #2  
(If rural, give LOCATION)  
2.(a) If veteran, name war WW-I

### 3. (a) FULL NAME

WILLIAMS, Charles B.

### 3. (b) Social Security Number

Unknown

|                       |                                  |  |
|-----------------------|----------------------------------|--|
| 4. Sex<br><u>Male</u> | 5. Color or race<br><u>White</u> | 6. (a) Single, married, widowed, or divorced<br><u>Married</u> |
|-----------------------|----------------------------------|--|

6. (b) Name of husband or wife Mildred P. Williams  
6. (c) If alive, give age ? years  
7. Birth date of deceased (mo., day, yr.) June 26, 1887  
8. AGE: Years 58 Months 11 Days 6 If less than one day  
..... hrs. .... min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 46 at 12:50 A  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 PM May 1 19 46 to May 2 19 46  
and that I last saw him alive on May 2 19 46

Immediate cause of death  
MYOCARDITIS, Chronic

DURATION

unknown

Due to .....  
Due to .....  
Other conditions Asthma, Bronchial unknown  
(Include pregnancy within 3 months of death)

Major findings of operations .....  
..... Date of op. ....

Autopsy results .....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ..... Date of .....  
Where did injury occur? ..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) .....  
Means of injury ..... Injured at work? .....

23. SIGNATURE H. C. CLARKE  
H. C. CLARKE, M.D., Manager D. or other  
Address VAH, Perry Point, Md. Date signed 5-2-46

9. Birthplace Berlin, Md.  
(Town, county, and state)  
10. Usual occupation Farmer  
11. Industry or business Farming  
12. Name Sampson Williams  
13. Birthplace Berlin, Md.  
14. Maiden name Leah C. Beathrods  
15. Birthplace Berlin, Md.  
16. Informant Records - Vets. Adm. Hospital  
Address Perry Point, Md.  
17. Removal Date thereof May 2, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Evergreen Cemetery  
Location Berlin, Md.  
18. Funeral director MRS. JOAN BURBATE,  
Address Berlin, Md.  
19. May 2 19 46 James E. Daugherty  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 4 1946  
BUREAU V.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

04763

Reg. Dist. No. 95

## 1. PLACE OF DEATH:

County Cecil  
 City or town Rising Sun  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Cecil  
 City or town Rising Sun  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rural Route #1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Janet Elaine Williams

## 3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28 1945

8. AGE: Years Months Days If less than one day  
 ✓ 8 21 hrs. min.

9. Birthplace Elkton, Cecil Co. Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Edward Marshall Williams13. Birthplace Union, Cecil Co. Md.14. Maiden name Kathryn McWilliams15. Birthplace Coatsville, Pa.16. Informant Edward M. WilliamsAddress Rising Sun #1, Md.17. Burial Date thereof May 23 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Elmwood CemeteryLocation Rising Sun Rd #3 Maryland18. Funeral director Joseph R. GrantAddress North East, Md.19. May 21 19 46  
(Date rec'd by registrar)Registrar Lyndie H. ThompsonPermit issued 1-21-46

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1946 at 2:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-18 1946 to 5-19 1946and that I last saw him alive on 5-19 1946

Immediate cause of death

DURATION

Bilateralbronchopneumonia

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert D. Wilson M.D.Address Rising Sun Md. M. D. or otherDate signed 5-21-46

SECRET

STANDARDIZATION

RECEIVED

MAY 28 1946

BUREAU V.B.

AMERICAN SLOGAN

PAG-CONTENT

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

### 1. PLACE OF DEATH:

County Cecil  
City or town Veterans Administration Hosp. Perry Point Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 months 27 days  
Hospital, institution, or street address where death occurred:  
Veterans Administration Hospital, Perry Point, Md.  
How long in hospital or institution? Same as above

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County -  
City or town 1014 Valley Street, Balto., Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1014 Valley Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war ★ WW I

### 3. (a) FULL NAME

WINGROVE, David F.

### 3. (b) Social Security Number

-

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife Ella Louise Fuller

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) October 13, 1898

8. AGE: Years 47 Months 7 Days 18 If less than one day  
hrs. min.

9. Birthplace Baltimore, Maryland.  
(Town, county, and state)

10. Usual occupation Lt. Police Department

11. Industry or business -

12. Name David S. Wingrove

13. Birthplace Baltimore, Md.

14. Maiden name Alice Devine

15. Birthplace Baltimore, Md.

16. Informant Hospital records

Address Veterans Administration Hospital  
Perry Point, Md.

17. Removal Removal Date thereof May 31, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Md.

18. Funeral director William Cook  
William Cook, St. Paul & Preston Sts.

Address Baltimore, Maryland.

19. May 31, 1946 Registrar James E. Douglas  
(Date registered by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1946, at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1945, to May 31 1946 and that I last saw him alive on May 31 1946

Immediate cause of death Cerebral arteriosclerosis Over 5 yrs.

Thrombosis 1 week  
Diabetes Mellitus Over 5 yrs.

Due to

Other conditions Psychosis with other  
somatic diseases 1 yr.  
(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results Not performed  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide 0 Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of Injury Injured at work? -

23. SIGNATURE J. E. Trollinger  
E. TROLLINGER, M.D. Clinical Director  
Address Veterans Administration Date signed 5-31-46  
Perry Point, Md.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

14765

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Pkton  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 Union Hospital

How long in hospital or institution? 17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil  
 City or town..... Port Deposit, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 165 Main  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Grace Miller Woodrow

## 3. (b) Social Security Number

4. Sex Female

5. Color or race white

6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William H. Woodrow

8. (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) April 3, 1888

8. AGE: Years 58 Months 1 Days 26 If less than one day hrs. min.

9. Birthplace Perryville, Cecil Co., Md.

10. Usual occupation housewife

11. Industry or business

12. Name George W. Woodrow

13. Birthplace Cecil Co., Md.

14. Maiden name Gertrude Price

15. Birthplace Harford Co., Md.

16. Informant Wm. H. Woodrow

Address Port Deposit

17. Burial Date thereof May 3, 1946

(Burial, cremation, or removal, Which?) Cemetery or crematory Harmony Chapel

Location Liberty, Cecil Co., Md.

18. Funeral director L. A. Patterson &amp; Son

Address Perryville, Md.

19. May 30, 1946 (Date rec'd by registrar) FR Frazee Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1946 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12, 1946 to May 29, 1946

and that I last saw h. alive on May 29, 1946

Immediate cause of death gangrene of finger leg

Due to Diabetic Mellitus

Due to severe

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. Davis Md.

Address Chesapeake, Md. Date signed 5/30/46

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JUN 2 1946

BUREAU V.S.